NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)

PREAMBLE

1. Sections Affected	**Rulemaking Action**
R9-22-101	Amend
R9-22-117	Repeal
R9-22-1406	Amend
R9-22-1408	Amend
R9-22-1410	Repeal
R9-22-1410	New Section
R9-22-1413	Amend
R9-22-1428	Amend
R9-22-1431	Amend
R9-22-1701	Repeal
R9-22-1701	New Section
R9-22-1702	Repeal
R9-22-1702	New Section
R9-22-1703	Repeal
R9-22-1703	New Section
R9-22-1704	Repeal
R9-22-1704	New Section
R9-22-1705	New Section

2. The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):

Authorizing statute: A.R.S. § 36-2903.01

Implementing statute: A.R.S. § 36-2903.01

3. The effective date of the rules:

The rules are effective 60 days after filing with the Secretary of State.

4. A list of all previous notices appearing in the *Register* addressing the final rules:

Notice of Rulemaking Docket Opening: 13 A.A.R. 2853, August 17, 2007

Notice of Proposed Rulemaking: 13 A.A.R. 4456, December 21, 2007

5. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:

Name: Mariaelena Ugarte

Address: AHCCCS
Office of Administrative Legal Services
701 E. Jefferson, Mail Drop 6200
Phoenix, AZ 85034

Telephone: (602) 417-4693

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E-mail: AHCCCSRules@azahcccs.gov

6. An explanation of the rule, including the agency's reasons for initiating the rule:

A.R.S. § 36-2901, as amended in 2007, requires the Administration to update the eligibility income limit to 150 percent of the Federal Poverty Level (FPL) for a pregnant woman. The Administration is also proposing amendments to the rules to revise, reorganize, and clarify the enrollment requirements as specified in the Section 1115 Waiver with Centers for Medicare and Medicaid Services (CMS).

7. A reference to any study relevant to the rule that the agency reviewed and either relied on in its evaluation of or justification for the rule or did not rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:

No study was reviewed during this rulemaking and the Agency does not anticipate reviewing any studies.

8. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

9. The summary of the economic, small business, and consumer impact:

It is anticipated that the contractors, private sector, members, providers, small businesses, political subdivisions, the Department, and the Administration will be minimally impacted by the changes to the rule language. The areas of rule that describe the Sixth Omnibus Reconciliation Act (SOBRA) pregnant woman's federal poverty level will be changed from 133% to 150%. This increase in FPL will allow more uninsured pregnant women to meet the income requirements and qualify for medical assistance. The Administration is proposing amendments to the rules to revise, reorganize, and clarify the enrollment requirements as specified in the Section 1115 waiver. The enrollment rule updates will have minimal to no impact since the changes provide further detail and clarity. Where the member was given 16 days to choose a plan, they now have 30 days. This increase in time to choose a plan will have a minimal impact to the Administration, where system changes will be required to allow for this change. The member will benefit from the additional time to decide which plan they prefer.

10. A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):

No substantive changes have been made between the proposed rules and the final rules. The Administration made the rules more clear, concise, and understandable by making grammatical, verb tense, punctuation, and structural changes throughout the rules.

11. A summary of the comments made regarding the rule and the agency response to them:

The Administration did not receive any comments regarding the rules.

12. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:

Not applicable

13. Incorporations by reference and their location in the rules:

Not applicable

14. Was this rule previously adopted as an emergency rule?

No

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

ADMINISTRATION

ARTICLE 1. DEFINITIONS

Section
R9-22-101. Location of Definitions
R9-22-117. ~~Enrollment Related Definitions~~ Repealed

ARTICLE 14. AHCCCS MEDICAL COVERAGE FOR FAMILIES AND INDIVIDUALS

Section
R9-22-1406. Application Process
R9-22-1408. Applicant and Member Responsibility
R9-22-1410. ~~Eligibility Interview or Home Visit~~ Department Responsibilities
R9-22-1413. Time-frames, Approval, Discontinuance, or Denial of an Application
R9-22-1428. Eligibility for a Person Not Eligible as a Family
R9-22-1431. Family Planning Services Extension Program (FPEP)

ARTICLE 17. ENROLLMENT

Section
R9-22-1701. ~~Enrollment of a Member with an AHCCCS Contractor~~ Enrollment-Related Definitions
R9-22-1702. ~~Effective Date of Enrollment with a Contractor and Notification to the Contractor~~ Enrollment of a Member with an AHCCCS Contractor
R9-22-1703. ~~Newborn Enrollment~~ Effective Date of Enrollment with a Contractor
R9-22-1704. ~~Guaranteed Enrollment Period~~ Newborn Enrollment
R9-22-1705. Guaranteed Enrollment Period

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

ARTICLE 1. DEFINITIONS

R9-22-101. Location of Definitions

A. Location of definitions. Definitions applicable to this Chapter are found in the following:

Definition	Section or Citation
"Accommodation"	R9-22-701
"Act"	R9-22-101
"ADHS"	R9-22-101
"Administration"	A.R.S. § 36-2901
"Adverse action"	R9-22-101
"Affiliated corporate organization"	R9-22-101
"Aged"	42 U.S.C. 1382c(a)(1)(A) and R9-22-1501
"Aggregate"	R9-22-701
"AHCCCS"	R9-22-101
"AHCCCS inpatient hospital day or days of care"	R9-22-701
"AHCCCS registered provider"	R9-22-101
"Ambulance"	A.R.S. § 36-2201
"Ancillary department"	R9-22-701
"Ancillary service"	R9-22-701
“Anticipatory guidance”	R9-22-201
"Annual enrollment choice"	~~R9-22-117~~ R9-22-1701
"APC"	R9-22-701
"Appellant"	R9-22-101
"Applicant"	R9-22-101
"Application"	R9-22-101

“Assessment”	R9-22-1101
"Assignment"	R9-22-101
"Attending physician"	R9-22-101
"Authorized representative"	R9-22-101
“Authorization”	R9-22-201
"Auto-assignment algorithm"	~~R9-22-117~~ R9-22-1701
“AZ-NBCCEDP”	R9-22-2001
"Baby Arizona"	R9-22-1401
"Behavior management services"	R9-22-1201
"Behavioral health adult therapeutic home"	R9-22-1201
"Behavioral health therapeutic home care services"	R9-22-1201
"Behavioral health evaluation"	R9-22-1201
"Behavioral health medical practitioner"	R9-22-1201
"Behavioral health professional"	R9-22-1201
"Behavioral health recipient"	R9-22-201
"Behavioral health service"	R9-22-1201
"Behavioral health technician"	R9-22-1201
"BHS"	R9-22-1401
"Billed charges"	R9-22-701
"Blind"	R9-22-1501
"Burial plot"	R9-22-1401
“Business agent”	R9-22-701 and R9-22-704
“Calculated inpatient costs”	R9-22-712.07
"Capital costs"	R9-22-701
"Capped fee-for-service"	R9-22-101
"Caretaker relative"	R9-22-1401
“Case management”	R9-22-1201
"Case record"	R9-22-101

"Case review"	R9-22-101
"Cash assistance"	R9-22-1401
~~"Categorically eligible"~~ "Categorically eligible"	R9-22-101
“CCR”	R9-22-712
"Certified psychiatric nurse practitioner"	R9-22-1201
“Charge master”	R9-22-712
“Child”	R9-22-1503 and R9-22-1603
“Children’s Rehabilitative Services” or "CRS"	~~R9-22-102~~ R9-22-201
“Claim”	R9-22-1101
“Claims paid amount”	R9-22-712.07
"Clean claim"	A.R.S. § 36-2904
"Clinical supervision"	R9-22-201
"CMDP"	~~R9-22-117~~ R9-22-1701
"CMS"	R9-22-101
"Continuous stay"	R9-22-101
"Contract"	R9-22-101
“Contract year”	R9-22-101
"Contractor"	A.R.S. § 36-2901
“Copayment”	R9-22-701, R9-22-711 and R9-22-1603
“Cost avoid”	R9-22-1201
"Cost-To-Charge Ratio"	R9-22-701
"Covered charges"	R9-22-701
"Covered services"	R9-22-101
"CPT"	R9-22-701
“Creditable coverage”	R9-22-2003 and 42 U.S.C. 300gg(c)
"Critical Access Hospital"	R9-22-701
“CRS”	R9-22-1401
"Cryotherapy"	R9-22-2001

“Customized DME”	R9-22-212
"Day"	R9-22-101 and R9-22-1101
“Date of the Notice of Adverse Action”	R9-22-1441
“DBHS”	R9-22-201
"DCSE"	R9-22-1401
"De novo hearing"	42 CFR 431.201
"Dentures” and "Denture services"	R9-22-201
"Department"	A.R.S. § 36-2901
"Dependent child"	A.R.S. § 46-101
"DES"	R9-22-101
"Diagnostic services"	R9-22-101
"Director"	R9-22-101
"Disabled"	R9-22-1501
"Discussion"	R9-22-101
"Disenrollment"	~~R9-22-117~~ R9-22-1701
"DME"	R9-22-101
"DRI inflation factor"	R9-22-701
"E.P.S.D.T. services"	42 CFR 440.40(b)
"Eligibility posting"	R9-22-701
"Eligible person"	A.R.S. § 36-2901
"Emergency behavioral health condition for the non-FES member"	R9-22-201
"Emergency behavioral health services for the non-FES member"	R9-22-201
"Emergency medical condition for the non-FES member"	R9-22-201
"Emergency medical services for the non-FES member"	R9-22-201
“Emergency medical or behavioral health condition for a FES member”	R9-22-217

"Emergency services costs"	A.R.S. § 36-2903.07
"Encounter"	R9-22-701
"Enrollment"	~~R9-22-117~~ R9-22-1701
"Enumeration"	R9-22-101
"Equity"	R9-22-101
"Experimental services"	R9-22-101
"Existing outpatient service"	R9-22-701
“Expansion funds”	R9-22-701
"FAA"	R9-22-1401
"Facility"	R9-22-101
"Factor"	R9-22-701 and 42 CFR 447.10
"FBR"	R9-22-101
"Federal financial participation" or "FFP"	42 CFR 400.203
"Federal poverty level" or "FPL"	A.R.S. § 36-2981
"Fee-For-Service" or "FFS"	R9-22-101
"FES member"	R9-22-101
"FESP"	R9-22-101
"First-party liability"	R9-22-1001
“File”	R9-22-1101
“Fiscal agent”	R9-22-210
“Fiscal intermediary”	R9-22-701
"Foster care maintenance payment"	42 U.S.C. 675(4)(A)
"FQHC"	R9-22-101
"Free Standing Children’s Hospital"	R9-22-701
“Fund”	R9-22-712.07
“Graduate medical education (GME) program”	R9-22-701
"Grievance"	R9-34-202
"GSA"	R9-22-101

"HCPCS"	R9-22-701
"Health care practitioner"	R9-22-1201
"Hearing aid"	R9-22-201
"HIPAA"	R9-22-701
"Home health services"	R9-22-201
"Homebound"	R9-22-1401
"Hospital"	R9-22-101
“In-kind income”	R9-22-1420
“Insured entity”	R9-22-720
"Intermediate Care Facility for the Mentally Retarded" or "ICF-MR"	42 USC 1396d(d)
"ICU"	R9-22-701
"IHS"	~~R9-22-117~~ R9-22-101
“IHS enrolled” or “enrolled with IHS”	R9-22-708
"IMD" or "Institution for Mental Diseases"	42 CFR 435.1010 and R9-22-201
"Income"	R9-22-1401 and R9-22-1603
“Indigent”	R9-22-1401
“Individual”	R9-22-211
"Inmate of a public institution"	42 CFR 435.1010
“Inpatient covered charges”	R9-22-712.07
"Interested party"	R9-22-101
“Intern and Resident Information System”	R9-22-701
“LEEP”	R9-22-2001
“Legal representative”	R9-22-101
"Level I trauma center"	R9-22-2101
"License" or "licensure"	R9-22-101
“Licensee”	R9-22-1201
"Liquid assets"	R9-22-1401

"Mailing date"	R9-22-101
"Medical education costs"	R9-22-701
"Medical expense deduction" or "MED"	R9-22-1401
"Medical record"	R9-22-101
"Medical review"	R9-22-701
"Medical services"	A.R.S. § 36-401
"Medical supplies"	R9-22-201
"Medical support"	R9-22-1401
"Medically necessary"	R9-22-101
"Medicare claim"	R9-22-101
"Medicare HMO"	R9-22-101
"Member"	A.R.S. § 36-2901
"Mental disorder"	A.R.S. § 36-501
“Milliman study”	R9-22-712.07
“Monthly equivalent”	R9-22-1421 and R9-22-1603
“Monthly income”	R9-22-1421 and R9-22-1603
"National Standard code sets"	R9-22-701
"New hospital"	R9-22-701
"NICU"	R9-22-701
“Noncontracted Hospital”	R9-22-718
"Noncontracting provider"	A.R.S. § 36-2901
"Non-FES member"	R9-22-201
"Non-IHS Acute Hospital"	R9-22-701
"Nonparent caretaker relative"	R9-22-1401
"Nursing facility" or "NF"	42 U.S.C. 1396r(a)
“OBHL”	R9-22-1201
“Observation day”	R9-22-701
"Occupational therapy"	R9-22-201

"Offeror"	R9-22-101
"Operating costs"	R9-22-701
“Organized health care delivery system”	R9-22-701
"Outlier"	R9-22-701
"Outpatient hospital service"	R9-22-701
"Ownership change"	R9-22-701
"Ownership interest"	42 CFR 455.101
“Parent”	R9-22-1603
"Partial Care"	R9-22-1201
“Participating institution”	R9-22-701
"Peer group"	R9-22-701
“Peer-reviewed study”	R9-22-2001
“Penalty”	R9-22-1101
"Pharmaceutical service"	R9-22-201
"Physical therapy"	R9-22-201
"Physician"	R9-22-101
“Physician assistant”	R9-22-1201
"Post-stabilization services"	R9-22-201 or 42 CFR 422.113
“PPC”	R9-22-701
“PPS bed”	R9-22-701
"Practitioner"	R9-22-101
"Pre-enrollment process"	R9-22-1401
“Premium”	R9-22-1603
"Prescription"	R9-22-101
"Primary care provider” or “PCP"	R9-22-101
"Primary care provider services"	R9-22-201
"Prior authorization"	R9-22-101
"Prior period coverage" or "PPC"	R9-22-701

"Procedure code"	R9-22-701
"Proposal"	R9-22-101
"Prospective rates"	R9-22-701
"Psychiatrist"	R9-22-1201
"Psychologist"	R9-22-1201
"Psychosocial rehabilitation services"	R9-22-201
"Public hospital"	R9-22-701
"Qualified alien"	A.R.S. § 36-2903.03
“Qualified behavioral health service provider”	R9-22-1201
"Quality management"	R9-22-501
"Radiology"	R9-22-101
"RBHA" or “Regional Behavioral Health Authority”	R9-22-201
“Reason to know”	R9-22-1101
"Rebase"	R9-22-701
"Referral"	R9-22-101
"Rehabilitation services"	R9-22-101
"Reinsurance"	R9-22-701
"Remittance advice"	R9-22-701
“Resident”	R9-22-701
"Residual functional deficit"	R9-22-201
"Resources"	R9-22-1401
"Respiratory therapy"	R9-22-201
“Respite”	R9-22-1201
"Responsible offeror"	R9-22-101
"Responsive offeror"	R9-22-101
"Revenue Code"	R9-22-701
"Review"	R9-22-101
"Review month"	R9-22-101

"RFP"	R9-22-101
“Rural Contractor”	R9-22-718
“Rural Hospital”	R9-22-712.07 and R9-22-718
"Scope of services"	R9-22-201
"Section 1115 Waiver"	A.R.S. § 36-2901
"Service location"	R9-22-101
"Service site"	R9-22-101
"SOBRA"	R9-22-101
"Specialist"	R9-22-101
“Specialty facility”	R9-22-701
"Speech therapy"	R9-22-201
"Spendthrift restriction"	R9-22-1401
“Sponsor”	R9-22-1401
“Sponsor deemed income”	R9-22-1401
“Sponsoring institution”	R9-22-701
"Spouse"	R9-22-101
"SSA"	42 CFR 1000.10
“SSDI Temporary Medical Coverage”	R9-22-1603
"SSI"	42 CFR 435.4
"SSN"	R9-22-101
"Stabilize"	42 U.S.C. 1395dd
"Standard of care"	R9-22-101
"Sterilization"	R9-22-201
"Subcontract"	R9-22-101
"Submitted"	A.R.S. § 36-2904
“Substance abuse”	R9-22-201
"SVES"	R9-22-1401
“Therapeutic foster care services”	R9-22-1201

"Third-party"	R9-22-1001
"Third-party liability"	R9-22-1001
"Tier"	R9-22-701
"Tiered per diem"	R9-22-701
"Title IV-D"	R9-22-1401
"Title IV-E"	R9-22-1401
“Total Inpatient payments”	R9-22-712.07
"Trauma and Emergency Services Fund"	A.R.S. § 36-2903.07
“TRBHA” or "Tribal Regional Behavioral Health Authority"	R9-22-1201
“Treatment”	R9-22-2004
"Tribal Facility"	A.R.S. § 36-2981
"Unrecovered trauma center readiness costs"	R9-22-2101
“Urban Contractor”	R9-22-718
“Urban Hospital”	R9-22-718
“USCIS”	R9-22-1401
"Utilization management"	R9-22-501
"WWHP"	R9-22-2001

B. General definitions. In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

"Act" means the Social Security Act.

"ADHS" means the Arizona Department of Health Services.

"Adverse action" means an action taken by the Department or Administration to deny, discontinue, or reduce medical assistance.

"Affiliated corporate organization" means any organization that has ownership or control interests as defined in 42 CFR 455.101, and includes a parent and subsidiary corporation.

"AHCCCS" means the Arizona Health Care Cost Containment System, which is composed of the Administration, contractors, and other arrangements through which health care services are provided to a member.

"AHCCCS registered provider" means a provider or noncontracting provider who:

Enters into a provider agreement with the Administration under R9-22-703(A), and

Meets license or certification requirements to provide covered services.

"Appellant" means an applicant or member who is appealing an adverse action by the Department or Administration.

"Applicant" means a person who submits or whose authorized representative submits~~,~~ a written, signed, and dated application for AHCCCS benefits.

"Application" means an official request for AHCCCS medical coverage made under this Chapter.

"Assignment" means enrollment of a member with a contractor by the Administration.

"Attending physician" means a licensed allopathic or osteopathic doctor of medicine who has primary responsibility for providing or directing preventive and treatment services for a Fee-For-Service member.

"Authorized representative" means a person who is authorized to apply for medical assistance or act on behalf of another person.

"Capped fee-for-service" means the payment mechanism by which a provider of care is reimbursed upon submission of a valid claim for a specific covered service or equipment provided to a member. A payment is made in accordance with an upper, or capped, limit established by the Director. This capped limit can be either a specific dollar amount or a percentage of billed charges.

"Case record" means an individual or family file retained by the Department that contains all pertinent eligibility information, including electronically stored data.

"Case review" means the Administration's evaluation of an individual's or family's circumstances and case record in a review month.

~~"Categorically eligible"~~ "Categorically eligible" means a person who is eligible under A.R.S. §§ 36-2901(6)(a)(i), (ii), or (iii) or 36-2934.

"CMS" means the Centers for Medicare and Medicaid Services.

"Continuous stay" means a period during which a member receives inpatient hospital services without interruption beginning with the date of admission and ending with the date of discharge or date of death.

"Contract" means a written agreement entered into between a person, an organization, or other entity and the Administration to provide health care services to a member under A.R.S. Title 36, Chapter 29, and this Chapter.

"Contract year" means the period beginning on October 1 of a year and continuing until September 30 of the following year.

"Covered services" means the health and medical services described in Articles 2 and 12 of this Chapter as being eligible for reimbursement by AHCCCS.

"Day" means a calendar day unless otherwise specified.

"DES" means the Department of Economic Security.

"Diagnostic services" means services provided for the purpose of determining the nature and cause of a condition, illness, or injury.

"Director" means the Director of the Administration or the Director's designee.

"Discussion" means an oral or written exchange of information or any form of negotiation.

"DME" means durable medical equipment, which is an item or appliance that can withstand repeated use, is designed to serve a medical purpose, and is not generally useful to a person in the absence of a medical condition, illness, or injury.

"Enumeration" means the assignment of a nine-digit identification number to a person by the Social Security Administration.

"Equity" means the county assessor full cash value or market value of a resource minus valid liens, encumbrances, or both.

“Experimental services” means services that are associated with treatment or diagnostic evaluation and that are not generally and widely accepted as a standard of care in the practice of medicine in the United States unless:

The weight of the evidence in peer-reviewed articles in medical journals published in the United States supports the safety and effectiveness of the service; or

In the absence of peer-reviewed articles, for services that are rarely used, novel, or relatively unknown in the general professional medical community, the weight of opinions from specialists who provide the service attests to the safety and effectiveness of the service.

"Facility" means a building or portion of a building licensed or certified by the Arizona Department of Health Services as a health care institution under A.R.S. Title 36, Chapter 4, to provide a medical service, a nursing service, or other health care or health-related service.

"FBR" means Federal Benefit Rate, the maximum monthly Supplemental Security Income payment rate for a member or a married couple.

"Fee-For-Service" or "FFS" means a method of payment by the AHCCCS Administration to a registered provider on an amount-per-service basis for a member not enrolled with a contractor.

"FES member" means a person who is eligible to receive emergency medical and behavioral health services through the FESP under R9-22-217.

"FESP" means the federal emergency services program under R9-22-217 which covers services to treat an emergency medical or behavioral health condition for a member who is determined eligible under A.R.S. § 36-2903.03(D).

"FQHC" means federally qualified health center.

"GSA" means a geographical service area designated by the Administration within which a contractor provides, directly or through a subcontract, a covered health care service to a member enrolled with the contractor.

"Hospital" means a health care institution that is licensed as a hospital by the Arizona Department of Health Services under A.R.S. Title 36, Chapter 4, Article 2, and certified as a provider under Title XVIII of the Social Security Act, as amended, or is currently determined, by the Arizona Department of Health Services as the CMS designee, to meet the requirements of certification.

"IHS" means Indian Health Service.

"Interested party" means an actual or prospective offeror whose economic interest may be directly affected by the issuance of an RFP, the award of a contract, or by the failure to award a contract.

“Legal representative” means a custodial parent of a child under 18, a guardian, or a conservator.

"License" or "licensure" means a nontransferable authorization that is granted based on established standards in law by a state or a county regulatory agency or board and allows a health care provider to lawfully render a health care service.

"Mailing date" when used in reference to a document sent first class, postage prepaid, through the United States mail, means the date:

Shown on the postmark;

Shown on the postage meter mark of the envelope, if no postmark; or

Entered as the date on the document if there is no legible postmark or postage meter mark.

"Medical record" means a document that relates to medical or behavioral health services provided to a member by a physician or other licensed practitioner of the healing arts and that is kept at the site of the provider.

"Medically necessary" means a covered service is provided by a physician or other licensed practitioner of the healing arts within the scope of practice under state law to prevent disease, disability, or other adverse health conditions or their progression, or to prolong life.

"Medicare claim" means a claim for Medicare-covered services for a member with Medicare coverage.

"Medicare HMO" means a health maintenance organization that has a current contract with Centers for Medicare and Medicaid Services for participation in the Medicare program under 42 CFR 417 Subpart L.

"Offeror" means an individual or entity that submits a proposal to the Administration in response to an RFP.

"Physician" means a person licensed as an allopathic or osteopathic physician under A.R.S. Title 32, Chapter 13 or Chapter 17.

"Practitioner" means a physician assistant licensed under A.R.S. Title 32, Chapter 25, or a registered nurse practitioner certified under A.R.S. Title 32, Chapter 15.

"Prescription" means an order to provide covered services that is signed or transmitted by a provider authorized to prescribe the services.

"Primary care provider" or "PCP" means an individual who meets the requirements of A.R.S. § 36-2901(12) or (13), and who is responsible for the management of a member's health care.

"Prior authorization" means the process by which the Administration or contractor, whichever is applicable, authorizes, in advance, the delivery of covered services contingent on the medical necessity of the services.

"Prior period coverage" means the period prior to the member's enrollment during which a member is eligible for covered services. PPC begins on the first day of the month of application or the first eligible month, whichever is later, and continues until the day the member is enrolled with a contractor.

"Proposal" means all documents, including best and final offers, submitted by an offeror in response to an RFP by the Administration.

"Radiology" means professional and technical services rendered to provide medical imaging, radiation oncology, and radioisotope services.

"Referral" means the process by which a member is directed by a primary care provider or an attending physician to another appropriate provider or resource for diagnosis or treatment.

"Rehabilitation services" means physical, occupational, and speech therapies, and items to assist in improving or restoring a person's functional level.

"Responsible offeror" means an individual or entity that has the capability to perform the requirements of a contract and that ensures good faith performance.

"Responsive offeror" means an individual or entity that submits a proposal that conforms in all material respects to an RFP.

"Review" means a review of all factors affecting a member’s eligibility.

"Review month" means the month in which the individual's or family's circumstances and case record are reviewed.

"RFP" means Request for Proposals, including all documents, whether attached or incorporated by reference, that are used by the Administration for soliciting a proposal under 9 A.A.C. 22, Article 6.

"Service location" means a location at which a member obtains a covered service provided by a physician or other licensed practitioner of the healing arts under the terms of a contract.

"Service site" means a location designated by a contractor as the location at which a member is to receive covered services.

"SOBRA" means Section 9401 of the Sixth Omnibus Budget Reconciliation Act, 1986, amended by the Medicare Catastrophic Coverage Act of 1988, 42 U.S.C. 1396a(a)(10)(A)(i)(IV), 42 U.S.C. 1396a(a)(10)(A)(i)(VI), and 42 U.S.C. 1396a(a)(10)(A)(i)(VII).

"Specialist" means a Board-eligible or certified physician who declares himself or herself as a specialist and practices a specific medical specialty. For the purposes of this definition, Board-eligible means a physician who meets all the requirements for certification but has not tested for or has not been issued certification.

"Spouse" means a person who has entered into a contract of marriage recognized as valid by this state.

"SSN" means Social Security number.

"Standard of care" means a medical procedure or process that is accepted as treatment for a specific illness, injury, or medical condition through custom, peer review, or consensus by the professional medical community.

"Subcontract" means an agreement entered into by a contractor with any of the following:

A provider of health care services who agrees to furnish covered services to a member,

A marketing organization, or

Any other organization or person ~~who~~ that agrees to perform any administrative function or service for the contractor specifically related to securing or fulfilling the contractor's obligation to the Administration under the terms of a contract.

R9-22-117. ~~Enrollment Related Definitions~~ Repealed

~~In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:~~

~~"Annual enrollment choice" means the annual opportunity for a person to change contractors.~~

~~"Auto-assignment algorithm" means the mathematical formula used by the Administration to assign persons to the various contractors.~~

~~"CMDP" means Comprehensive Medical and Dental Program.~~

~~"Disenrollment" means the discontinuance of a person's entitlement to receive covered services from a contractor of record.~~

~~"Enrollment" means the process by which an eligible person becomes a member of a contractor's plan.~~

~~"IHS" means Indian Health Service.~~

ARTICLE 14. AHCCCS MEDICAL COVERAGE FOR FAMILIES AND INDIVIDUALS

R9-22-1406. Application Process

A. Right to apply. A person ~~identified in subsection (B)~~ may apply for AHCCCS medical coverage by submitting ~~a signed Department approved or~~ an Administration-approved written application to the Administration, an FAA office, or one of the following outstation locations ~~under 42 CFR 435.904~~:

1. A BHS site ~~as provided in A.R.S. § 36-3431~~;
2. ~~A CRS site as provided in A.R.S. § 36-261~~ A facility contracted with CRS Administration;
3. A Baby Arizona-approved provider's office, if the applicant is a pregnant woman;
4. A Federally Qualified Health Center or disproportionate share hospital under 42 U.S.C. 1396r-4; or
5. Any other site, including a hospital, approved by the Department or the Administration.

~~**B.** Who may apply for a person. Any of the following may submit an application for an applicant:~~

~~1. The applicant's legal representative;~~

~~2. The applicant;~~

~~3. The applicant's spouse;~~

~~4. The applicant's parent;~~

~~5. The applicant's authorized representative, designated by the applicant either in writing or verbally in the presence of an employee of the Administration or Administration's designee;~~

~~6. An adult who lives with the applicant;~~

~~7. The applicant's adult child; or~~

~~8. Another party if the applicant is:~~

~~a. A child less than 18 years old;~~

~~b. A child who is age 18 and a student; or~~

~~c. An adult who is incapacitated. The Administration or Administration's designee shall require incapacity to be verified by written documentation signed by a licensed physician or by one of the following:~~

~~i. A physician assistant;~~

~~ii. A nurse practitioner; or~~

~~iii. A registered nurse, under the direction of a licensed physician.~~

~~C.~~**B.** Written application. To initiate the application process, ~~a~~ any person ~~listed in subsection (B)~~ may apply by ~~shall submit~~ submitting a written application under 42 CFR 435.907 with the appropriate signatures to one of the sites listed in subsection (A) ~~under 42 CFR 435.907 to one of the sites listed in subsection (A)~~.

1. A written application is one that contains the: ~~legible name and address, or location where the applicant can be reached, of each person requesting AHCCCS medical coverage and the signature of the person who is submitting the application.~~
   a. Applicant's legible name,
   b. Address or location where the applicant can be reached,
   c. Signature of the person listed in subsection (D)(2) or (D)(3),
   d. Date the application was signed.
2. The Administration or Administration's designee shall require that a third party witness the signing and attest by signing the application if the individual signing the application signs with a mark.
3. The Administration or Administration's designee shall accept an application for a person who is incapacitated and whose name and address are unknown.

~~D.~~**C.** Date of application. The date of application is the date a written application is received by the Administration or its designee at a location listed in subsection (A).

~~E.~~**D.** Complete application form.

1. ~~An applicant or a person applying on behalf of the applicant shall provide all information requested on the application form.~~ The Administration shall consider an application complete when:
   a. All questions are answered; and
   b. All necessary verification is provided by an applicant or an applicant's representative.
2. The Administration or Administration's designee shall not approve an application unless the applicant's legal representative, if one exists, signs the declarations on the application relating to the applicant's eligibility, under penalty of perjury.
3. If there is no legal representative, or the legal representative is incapacitated, one of the following shall sign the declarations on the application relating to the applicant's eligibility, under penalty of perjury:
   a. The applicant, if age 18 or older;
   b. The applicant, if less than 18 years old and married or not living with a parent;

c. The applicant's spouse if the applicant and spouse are not legally separated;

d. An adult who lives with an applicant ~~who~~ , if the applicant is less than 18 years old or age 18 and a student;

e. One of the unmarried partners if living together with a child in common, if the child is the applicant; ~~or~~

f. Another party, if the applicant is incapacitated and no one listed in subsections ~~(E)(3)(a)~~ (D)(3)(a) through (e) is available to sign the application on the applicant's behalf. The Administration shall require incapacity to be verified by written documentation signed by a licensed physician or by one of the following:

i. A physician assistant,

ii. A nurse practitioner, or

iii. A registered nurse under the direction of a licensed physician~~.~~; or

g. ~~A person listed in subsection (E)(2) or (E)(3)(a) through (e) may authorize, verbally in the presence of an employee of the Administration or Administration's designee or in writing, someone else to represent the applicant in the application process. The authorized representative may sign the declarations on the application relating to the applicant's eligibility, under penalty of perjury.~~

A person authorized verbally in the presence of an employee of the Administration or the Administration's designee or in writing, by a person listed in subsection (D)(2) or (D)(3)(a) through (c), to represent the applicant in the application process. The authorized representative may sign the declaration on the application relating to the applicant's eligibility, under penalty or perjury.

4. Unmarried adults not applying for a child in common shall each sign the application if using the same application form.

5. The application shall be witnessed and signed by a third party if the individual signing the application signs with a mark.

6. If the application is incomplete, the Administration or the Administration's designee shall do at least one of the following:

a. Contact an applicant or an applicant's representative by telephone or electronic medium to obtain the missing information required for an eligibility determination;

b. Mail a request for additional information to an applicant or an applicant's representative, allowing 10 days from the date of the request to provide the required additional information; or

c. Meet with the applicant, representative, or household member.

~~F.~~**E.** Assistance with application. The Administration or Administration's designee shall allow a person of the applicant's choice to accompany, assist, and represent the applicant in the application process.

R9-22-1408. Applicant and Member Responsibility

A. An applicant and a member shall authorize the Department to obtain verification for initial eligibility or continuation of eligibility.

B. As a condition of eligibility, an applicant or a member shall:

1. ~~Give~~ Provide the Department with complete and truthful information. The Department may deny an application or discontinue eligibility if:
   a. The applicant or member fails to provide information necessary for initial or continuing eligibility;
   b. The applicant or member fails to provide the Department with written authorization to permit the Department to obtain necessary initial or continuing eligibility verification;
   c. The applicant or member fails to provide verification under R9-22-1412 after the Department made an effort to obtain the necessary verification but has not obtained the necessary information; or
   d. The applicant or member does not assist the Department in resolving incomplete, inconsistent, or unclear information that is necessary for initial or continuing eligibility;
2. Cooperate with the Division of Child Support Enforcement (DCSE) in establishing paternity and enforcing medical support obligations when requested unless good cause exists for not cooperating under 42 CFR 433.147 as of ~~January 19, 1993~~ October 1, 2006, which is incorporated by reference, ~~and~~ on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol ~~Street~~ St., NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments. The Department shall not deny AHCCCS eligibility to an applicant who would otherwise be eligible, is a minor child, and whose parent or legal representative does not cooperate with the medical support requirements under subsection (E) or first- and third-party liability requirements under Article 10 of this Chapter; and

3. Provide the following information concerning third-party coverage for medical care.:

   a. Name of policyholder,

   b. Policyholder's relationship to the applicant or member,

   c. SSN of the policy holder,

   d. Name and address of the insurance company, and

   e. Policy number.

C. A member or an applicant shall:

1. Send to the Department any medical support payments received while the member is eligible resulting that result from a medical support order;
2. Cooperate with the Administration or Administration's designee regarding any issues arising as a result of the Medicaid Eligibility Quality Control Program under Article 9 of this Chapter described under A.R.S. § 36-2903.01; and
3. Inform the Department of the following changes within 10 days from the date the applicant or member knows of a change:
   a. In address;
   b. In the household's composition;
   c. In income;
   d. In resources, when required under R9-22-1438 for the Medical Expense Deduction (MED) program;
   e. In Arizona state residency;
   f. In citizenship or immigrant status;
   g. In first- or third-party liability that may contribute to the payment of all or a portion of the person's medical costs; or
   h. That may affect the member's or applicant's eligibility, including a change in a woman's pregnancy status.

D. As a condition of eligibility, an applicant or a member shall apply for other benefits as required under 42 CFR 435.608 as of November 21, 1990 October 1, 2006, which is incorporated by reference, and on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol

~~Street~~ St., NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.

E. As a condition of eligibility, an applicant or a member shall cooperate with the ~~Assignment of Rights~~ assignment of rights under R9-22-1404. If the applicant or member receives medical care and services for which a first or third party is or may be liable, the applicant or member shall~~:~~

1. ~~Cooperate~~ cooperate with the Department and the Administration in identifying and providing information to assist the Department and the Administration in pursuing any first or third party who is or may be liable to pay for medical care and services.
2. ~~Except as provided in subsections (E)(3) and (E)(4), a parent, legal representative, or other legally responsible adult who applies for AHCCCS medical coverage on behalf of a child shall cooperate with the Department to establish paternity and obtain medical support or other payments as provided in A.R.S. § 46-292(C).~~
3. ~~A pregnant woman under A.R.S. § 36-2901(6)(a)(ii) is not required to provide the Department with information regarding paternity or medical support from a father of a child born out of wedlock.~~
4. ~~A parent who is not requesting AHCCCS medical coverage for himself or herself is not required to provide the Department with information regarding paternity or medical support from an absent parent under R9-22-1427(E).~~

~~**F.** At an initial application interview and at any review, the Department shall explain to an applicant or member the following requirements~~

1. ~~To cooperate with DCSE in establishing paternity and enforcing medical support, except in circumstances when good cause under 42 CFR 433.147 exists for not cooperating;~~
2. ~~To establish good cause for not cooperating with DCSE in establishing paternity and enforcing medical support;~~
3. ~~To report a change listed in subsection (C)(3) no later than 10 days from the date the applicant or member knows of the change;~~
4. ~~To send to the Department any medical support received through a Title IV-D court order; and~~
5. ~~To cooperate with the Department and Administration's assignment of rights and securing payments received from any liable party for a member's medical care.~~

~~**G.** An applicant or member shall provide the following health insurance information, if applicable, at the initial interview, within 10 days of becoming aware of a new source of health insurance, and at any eligibility review:~~

~~1. Name of policyholder,~~

~~2. Policyholder's relationship to the applicant or member,~~

~~3. SSN of the policy holder,~~

~~4. Name and address of the insurance company, and~~

~~5. Policy number.~~

F. As a condition of eligibility of a child whose parent, legal representative, or other legally responsible adult applies for AHCCCS medical coverage on behalf of the child, the individual who applies for the child shall cooperate with the Department to establish paternity and obtain medical support or other payments as provided in A.R.S. § 46-292(C). However, a pregnant woman under A.R.S. § 36-2901(6)(a)(ii) is not required to provide the Department with information regarding paternity or medical support from a father of a child born out of wedlock.

R9-22-1410. ~~Eligibility Interview or Home Visit~~ Department Responsibilities

~~**A.** Scheduling an interview or home visit.~~

~~1. Upon receipt of an application, the Department shall:~~

~~a. Schedule an initial eligibility interview or a home visit if requested by a homebound applicant or if the Department believes that a home visit may avoid an eligibility error, and~~

~~b. Provide the applicant a written notice of the scheduled interview or home visit.~~

~~2. The Department shall not require an initial interview or home visit under subsection (A)(1) unless the application received does not include sufficient information to determine eligibility under this Article for an applicant whose application is received from:~~

~~a. A Baby Arizona provider,~~

~~b. A KidsCare office under 9 A.A.C. 31,~~

~~c. A CRS site,~~

~~d. A BHS site, or~~

~~e. Another agency or entity approved by the Administration to conduct an interview.~~

B. Attending the interview. As a condition of eligibility, the applicant or the applicant's representative shall attend any required interview.

C. Good cause for failure to attend an interview.

1. Upon request, the Department shall reschedule the initial interview if the applicant or member or the applicant's or member's representative had good cause for missing the interview and a request for a rescheduled interview is made by the 45th day from the date of application. Good cause includes:
    a. Hospitalization,
    b. Illness,
    c. Serious injury or accident involving an applicant or member of the applicant's or member's household that made it impossible to contact the local FAA office, or
    d. Any unanticipated occurrence that made it impossible to contact the local FAA office.
2. Notwithstanding subsection (C)(1), the Department shall deny the applicant's or member's eligibility if the second interview is missed.

D. Department's obligations at the eligibility interview. During the initial interview or eligibility review interview, a Department representative shall:

1. Offer to help the applicant or member to complete the application form and to obtain required verification;
2. Provide the applicant or member with information explaining:
    a. The eligibility and verification requirements for AHCCCS medical coverage,
    b. The requirement that the applicant or member obtain and provide a SSN to the Department,
    c. How the Department uses the SSN,
    d. The Department's practice of exchanging eligibility and income information through the SVES,
    e. The applicant and member's right to appeal an adverse action under R9-22-1441,
    f. The assignment of rights under operation of law as provided in A.R.S. § 36-2903,
    g. That the Department will use information to complete data matches with potentially liable parties,
    h. The eligibility review process,
    i. The program coverage and the types of services available under each program,
    j. The AHCCCS pre-enrollment process,
    k. Availability of continued AHCCCS medical coverage under R9-22-1427,

~~l. That the Department shall use the Systematic Alien Verification for Entitlements (SAVE) process to verify eligible alien status, and~~

~~m. That the Department shall help the applicant or member obtain necessary verification if the applicant or member asks for help;~~

~~3. Review the penalties for perjury and fraud printed on the application;~~

~~4. Review any verification items provided by the applicant or member and give a written list of additional verification items and time frames within which the applicant or member shall provide information to the Department;~~

~~5. Explain the applicant and member's responsibilities under R9-22-1408;~~

~~6. Review all reporting requirements and explain that the applicant or member may lose the earned income disregards defined in R9-22-1420 if the applicant or member fails to timely report earned income changes; and~~

~~7. Explain the MED program under R9-22-1435 through R9-22-1440~~

A. The Department shall provide during the application process to the applicant or member information explaining the requirements to:

1. Cooperate with DCSE in establishing paternity and enforcing medical support, except in circumstances when good cause under 42 CFR 433.147 exists for not cooperating;
2. If applicable, establish good cause for not cooperating with DCSE in establishing paternity and enforcing medical support;
3. Report a change listed in R9-22-1408(C)(3) no later than 10 days from the date the applicant or member knows of the change;
4. Send to the Department any medical support payments received through a Title IV-D court order; and
5. Cooperate with the Department's and Administration's assignment of rights and securing payments received from any liable party for a member's medical care.

B. At initial application or eligibility review a Department representative shall:

1. Offer to help the applicant or member to complete the application form and to obtain required verification;
2. Provide the applicant or member with information explaining:
   a. The eligibility and verification requirements for AHCCCS medical coverage,

b. The requirement that the applicant or member obtain and provide a SSN to the Department,

c. How the Department uses the SSN,

d. The Department's practice of exchanging eligibility and income information through the State Verification and Exchange System (SVES),

e. The applicant and member's right to appeal an adverse action under R9-22-1441,

f. The assignment of rights under operation of law as provided in A.R.S. § 36-2903,

g. That the Department will use any information provided by the member to complete data matches with potentially liable parties,

h. The eligibility review process,

i. The program coverage and the types of services available under each program,

j. The AHCCCS pre-enrollment process,

k. Availability of continued AHCCCS medical coverage under R9-22-1427,

l. That the Department will use the Systematic Alien Verification for Entitlements (SAVE) process to verify eligible alien status, and

m. That the Department will help the applicant or member obtain necessary verification if the applicant or member asks for help;

3. Provide information regarding the penalties for perjury and fraud printed on the application;

4. Review any verification items provided by the applicant or member and inform the member of any additional verification items and time-frames within which the applicant or member shall provide information to the Department;

5. Explain to the applicant or member the applicant’s and member's responsibilities under R9-22-1408;

6. Provide information regarding all reporting requirements and explain to the applicant or member that the applicant or member may lose the earned income disregards under R9-22-1420 if the applicant or member fails to timely report earned income changes.

R9-22-1413. Time-frames, Approval, Discontinuance, or Denial of an Application

A. Application processing time. The Department shall complete an eligibility determination under 42 CFR 435.911 within 45 days after the application date under R9-22-1406 unless:

1. The applicant is pregnant. The Department shall ~~determine eligibility~~ complete an eligibility determination for a pregnant woman within 20 days after the application date unless additional information is required to determine eligibility; or
2. The applicant is in a hospital as an inpatient at the time of application. Within seven days of the Department's receipt of a signed application the Department shall~~:~~ complete an eligibility determination if the Department does not need additional information or verification to determine eligibility.
   ~~a. Complete an eligibility interview and ask all of the questions on the application, and~~
   ~~b. Complete an eligibility determination if the Department does not need additional information or verification to determine eligibility.~~

B. Approval. If the applicant meets all the eligibility requirements and conditions of eligibility of this Article, the Department shall approve the application and provide the applicant with an approval notice. The approval notice shall contain:

1. The name of each approved applicant,
2. The effective date of eligibility as defined in R9-22-1416 for each approved applicant,
3. The reason and the legal citations if a member is approved for only emergency medical services, and
4. The applicant's right to appeal the decision under R9-22-1441(A).

C. Denial. If an applicant fails to meet the eligibility requirements or conditions of eligibility of this Article, the Department shall deny the application and provide the applicant with a denial notice. The denial notice shall contain:

1. The name of each ineligible applicant,
2. The specific reason why the applicant is ineligible,
3. The income and resource calculations for the applicant compared to the income or resource standards for eligibility when the reason for the denial is due to the applicant's income or resources exceeding the applicable standard,
4. The legal citations supporting the reason for the ineligibility,
5. The location where the applicant can review the legal citations,
6. The date of ~~ineligibility,~~ the application being denied; and
7. The applicant's right to appeal the decision and request a hearing.

D. The Department shall reopen an application or reinstate eligibility of a member when any of the following conditions are met:

1. The denial or discontinuance of eligibility was due to an administrative error,
2. The discontinuance of eligibility was due to noncompliance with a condition of eligibility and the applicant or member complies prior to the effective date of the discontinuance,
3. The member informs the Department of a change of circumstances prior to the effective date of the discontinuance, that would allow for continued eligibility, or
4. ~~The~~ Following a discontinuance the member requests and is eligible for continuation of medical coverage pending an appeal under R9-22-1441.

R9-22-1428. Eligibility for a Person Not Eligible as a Family

Income standards. A person who is not approved in a family unit under R9-22-1427 but meets all the eligibility requirements in the Article is eligible for AHCCCS medical coverage if countable income does not exceed the following percentage of the FPL:

1. 150 percent for a pregnant woman,

~~1.~~2. 140 percent for a child under one year of age,

~~2.~~3. 133 percent for a ~~pregnant woman or a~~ child age one through five years of age, or

~~3.~~4. 100 percent for all other persons.

R9-22-1431. Family Planning Services Extension Program (FPEP)

A. A member who loses eligibility for AHCCCS medical coverage under R9-22-1430 due to the postpartum period ending and who has no other creditable coverage, as specified in 42 U.S.C. 300gg(c), may receive up to 24 months of family planning services as provided in this Section and A.R.S. § 36-2907.04.

B. Review of eligibility.

1. The Department shall complete a review of each member's continued eligibility for FPEP at least once every 12 months.
2. If a member continues to meet all eligibility requirements, the Department shall authorize continued eligibility for the FPEP and notify the member of continued eligibility.

3. The Department shall discontinue eligibility and notify the member of the discontinuance under R9-22-1415 if the member:
    a. Has income that exceeds ~~133~~ 150 percent of the FPL at the time of the 12-month review,
    b. Fails to comply with a review of eligibility under this subsection, or
    c. Meets any of the criteria under subsection (D).

C. Changes in the member's income after the initial or review eligibility determination shall not impact the member's eligibility during the following 12-month period.

D. The Administration or its designee shall deny or terminate a member from FPEP under this Section if the member:

1. Voluntarily withdraws from the program~~;~~,
2. Has whereabouts that are unknown~~;~~,
3. Fails to provide information to the Administration or ~~Department;~~ the Administration's designee,
4. Becomes an inmate of a public institution~~;~~,
5. Moves out-of-state~~;~~,
6. Has creditable coverage under 42 U.S.C. 300gg(c) ~~;~~,
7. Fails to meet the documentation requirements for U.S. citizenship or legal alien status under A.R.S. § 36-2903.03~~;~~,
8. Becomes eligible under 9 A.A.C. ~~Chapter~~ 22, 9 A.A.C. ~~Chapter~~ 28, or 9 A.A.C. ~~Chapter~~ 31 for full services under Article 2 of this Chapter;
9. Becomes sterile~~, ;~~ or
10. Dies.

E. The Administration or its designee shall not reinstate eligibility under this Section after the effective date of a discontinuance of eligibility unless the discontinuance is overturned on appeal or resulted from an administrative error.

R9-22-1701. ~~Enrollment of a Member with an AHCCCS Contractor~~ Enrollment-Related Definitions

~~**A.** General Enrollment Requirements.~~

~~1. Except as provided in subsections (A)(3), (A)(4), and (C), a member, determined eligible under this Chapter and residing in an area served by more than one contractor, shall have freedom of choice in the~~

~~selection of a contractor serving the member's GSA within 16 days from the date of the initial interview. A Native American member may select IHS or another available contractor.~~

2. ~~If the member does not make a choice, the Administration shall auto-assign the member to IHS if the member is a Native American living on a reservation, a contractor based on family continuity, or the auto-assignment algorithm.~~
3. ~~The Administration shall enroll a member with the member's most recent contractor of record, if available, if the member's period of ineligibility and disenrollment from the contractor of record is for a period of less than 90 days except if:~~
    a. ~~The member no longer resides in the contractor's GSA;~~
    b. ~~The contractor's contract is suspended or terminated;~~
    c. ~~The member was previously enrolled with CMDP but at the time of re-enrollment the member is not a foster care child;~~
    d. ~~The member chooses another contractor or chooses IHS, if available to the member, during the annual enrollment choice period; or~~
    e. ~~The member was previously enrolled with a contractor but at the time of re-enrollment the member is a foster care child.~~
4. ~~The Administration shall not enroll a member with a contractor if a member:~~
    a. ~~Is eligible for the FESP under R9-22-1418;~~
    b. ~~Is eligible for a period less than 30 days from the date the Administration receives notification of a member's eligibility, except for a member who is enrolled with CMDP or IHS;~~
    c. ~~Is eligible only for a retroactive period of eligibility, except for a member who is enrolled with IHS;~~
    d. ~~Is not a Native American and resides in an area not served by a contractor; or~~
    e. ~~Is a Native American and resides in an area not served by a contractor or IHS.~~

B. ~~Fee-for-service coverage. A member not enrolled with a contractor under subsection (A)(4) shall obtain covered medical services from an AHCCCS-registered provider on a fee-for-service basis under Article 7:~~

C. ~~Foster care child. The Administration shall enroll a member with CMDP if the member is a foster care child under A.R.S. § 8-512.~~

~~**D.** Family Planning Services Extension Program. A member eligible for the Family Planning Services Extension Program, as under R9-22-1424, shall remain enrolled with the member's contractor of record, or IHS.~~

~~**E.** Contractor or IHS enrollment change for a member.~~

~~1. The Administration shall change a member's enrollment if the member requests a change to an available contractor or IHS during an annual enrollment period. A Native American may change from an available contractor to IHS or from IHS to an available contractor at any time.~~

~~2. The Administration shall approve a change for an enrolled member under this Article, or as determined by the Director.~~

~~3. The Administration shall approve a change in enrollment for any member if the change is a result of the final outcome of a grievance under Article 8.~~

~~4. A member may choose a different contractor if the member moves into a GSA not served by the current contractor or if the contractor is no longer available. If the member does not select a contractor, the Administration shall auto-assign the member as provided in subsection (A)(2).~~

In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

"Annual enrollment choice" means the annual opportunity for a person to change contractors.

"Auto-assignment algorithm" or “Algorithm” means a formula used by the Administration to assign to a contractor a member who did not make a timely choice under R9-22-1702.

"CMDP" means Comprehensive Medical and Dental Program.

"Disenrollment" means the discontinuance of a person's entitlement to receive covered services from a contractor of record.

"Enrollment" means the process by which an eligible person becomes a member of a contractor's plan.

R9-22-1702. ~~Effective Date of Enrollment with a Contractor and Notification to the Contractor~~ Enrollment of a Member with an AHCCCS Contractor

~~**A.** Effective date of enrollment. A member's date of enrollment is the date enrollment action is taken by the Administration.~~

~~**B.** Financial liability of the contractor. The contractor shall be financially liable for an enrolled member's care as specified in contract.~~

~~**C.** Notice to contractor. The Administration shall notify the contractor of each member's enrollment with the contractor as specified in contract.~~

A. General enrollment requirements. The Administration shall enroll a member with a contractor as described in this Section, unless the member has pre-selected a contractor on the application:

1. Except as provided in subsections (A)(3), (A)(5), and (C), a member who is determined to be eligible under this Chapter and resides in an area served by more than one contractor, may choose an available contractor serving the member's GSA within 30 days from the date of notice of enrollment. A Native American member may select IHS or another available contractor.
2. If the member does not make a choice under subsection (A)(1), the Administration shall immediately auto-assign the member to:
    a. IHS if the member is a Native American living on a reservation,
    b. A contractor based on family continuity, or
    c. A contractor by using the auto-assignment algorithm.
3. If the member's period of ineligibility and disenrollment from the contractor of record is for a period of less than 90 days, the Administration shall enroll the member with the member's most recent contractor of record, if available, except if:
    a. The member no longer resides in the contractor's GSA;
    b. The contractor's contract is suspended or terminated;
    c. The member was previously enrolled with CMDP but at the time of re-enrollment the member is not a foster care child;
    d. The member chooses another contractor or chooses IHS, if available to the member, during the annual enrollment choice period; or
    e. The member was previously enrolled with a contractor but at the time of re-enrollment the member is a foster care child.
4. When the member’s disenrollment period is more than 90 days, the member may select a contractor as described in subsection (A)(1).

5. The Administration shall not enroll a member with a contractor if a member:

a. Is eligible for the FESP under R9-22-1419;

b. Is eligible for less than 30 days from the date the Administration receives notification of a member's eligibility, except for a member who is enrolled with CMDP or IHS;

c. Is eligible only for a retroactive period of eligibility, except for a member who is enrolled with CMDP or IHS; or

d. Resides in an area not served by a contractor.

B. Fee-for-service coverage. A member not enrolled with a contractor under subsection (A)(5) shall obtain covered medical services from an AHCCCS-registered provider on a fee-for-service basis under Article 7.

C. Foster care child. The Administration shall enroll a member with CMDP if the member is a foster care child under A.R.S. § 8-512.

D. Family Planning Services Extension Program. A member eligible for the Family Planning Services Extension Program under R9-22-1431, shall remain enrolled with the member's contractor of record or IHS.

E. Contractor or IHS enrollment change for a member.

1. The Administration shall change a member's enrollment if the member requests a change to an available contractor or IHS during an annual enrollment period. A Native American may change from an available contractor to IHS or from IHS to an available contractor at any time.

2. The Administration shall approve a change in enrollment for any member if the change is a result of the final outcome of a grievance under 9 A.A.C. 34.

3. A member may choose a different contractor if the member moves into a GSA not served by the current contractor or if the contractor is no longer available. If the member does not select a contractor, the Administration shall auto-assign the member as provided in subsection (A)(2).

4. The Administration shall provide the member 60 day advance notice of the member’s option to change plans by the member’s annual enrollment date.

5. A member may disenroll from a plan if:

a. The member moves out of the GSA;

b. The plan does not, because of moral or religious objections, cover the service a member seeks; or

c. The member needs related services to be performed at the same time; not all related services are available within the network; and the member's primary care provider or another provider determines that receiving the services separately would subject the member to unnecessary risk.

6. For exceptions to this article, the Administration shall approve a change for an enrolled member as determined by the Director.

R9-22-1703. ~~Newborn Enrollment~~ Effective Date of Enrollment with a Contractor

~~**A.** General.~~

~~1. The Administration shall enroll a newborn child of an AHCCCS eligible mother with a contractor or IHS, based on the mother's enrollment.~~

~~2. The Administration shall auto-assign a newborn child of an AHCCCS eligible mother who is not enrolled with a contractor or who is enrolled with CMDP.~~

~~3. The Administration shall notify the mother of the right to choose a different contractor for her child within 16 days from the date of the initial interview.~~

~~**B.** Financial liability for all newborns. The contractor shall be financially liable for the medical care of a newborn as specified in contract.~~

~~**C.** Notification to mother. The Administration shall notify the mother of the newborn's enrollment.~~

~~**D.** Choice. The Administration shall give the mother of the newborn an opportunity to select a different contractor or IHS, if available, for the newborn.~~

A. Effective date of enrollment. A member's date of enrollment is the date enrollment action is taken by the Administration. However, if a plan change occurs for an annual enrollment choice, the effective date is the month of the member's enrollment anniversary date.

B. Financial liability of the contractor. The contractor shall be financially liable for an enrolled member's care as specified in contract.

R9-22-1704. ~~Guaranteed Enrollment Period~~ Newborn Enrollment

~~**A.** General. Except for members enrolled with IHS or CMDP, the Administration shall provide a guaranteed enrollment period for a one-time period which begins on the effective date of the member's initial enrollment with the contractor and ends on the last day of the fifth full calendar month.~~

~~**B.** Exceptions to guaranteed period. The Administration shall not grant a guaranteed enrollment period or shall terminate a guaranteed enrollment period as provided in subsection (C), if the member:~~

~~1. Was factually ineligible when initially enrolled with the contractor,~~

~~2. Except as provided in 9 A.A.C. 22, Article 12, is an inmate of a public institution as defined in 42 CFR 435.1009,~~

~~3. Dies,~~

~~4. Moves out of state,~~

~~5. Voluntarily withdraws from the AHCCCS program, or~~

~~6. Is adopted.~~

~~**C.** Disenrollment effective date. The Administration shall terminate any guaranteed enrollment period to which the member is not entitled effective on:~~

~~1. The date the member is admitted to a public institution under subsection (B);~~

~~2. The member's date of death;~~

~~3. The last day of the month in which the Administration receives notification that a member moved out of state;~~

~~4. The date the Administration receives written notification of the member's voluntary withdrawal from the AHCCCS program; or~~

~~5. The date adoption proceedings are initiated through a private party, if known, or on the last day of the month in which the Administration receives notification of the proceedings.~~

~~**D.** Retroactive adjustments. The Administration shall adjust the member's eligibility and enrollment retroactively as under subsection (C).~~

A. General.

1. The Administration shall enroll a newborn child of an eligible mother with an available contractor or IHS, based on the mother's enrollment.
2. The Administration shall auto-assign a newborn child of an eligible mother who is not enrolled with a contractor or IHS or who is enrolled with CMDP. When a mother enrolled in CMDP has a newborn and the newborn is surrendered to Administration on Children, Youth and Families (ACYF), the newborn is then enrolled with CMDP.

3. The Administration shall notify the mother of the right to choose a different contractor for her newborn child. The mother may make her choice within 30 days from the date of notice of enrollment.

B. Financial liability for newborns. The contractor shall be financially liable for the medical care of a newborn as specified in contract.

R9-22-1705. Guaranteed Enrollment Period

A. General. Except for members enrolled with IHS or CMDP, the Administration shall provide a guaranteed enrollment period for a one time period that begins on the effective date of the member's initial enrollment with a contractor and ends on the last day of the fifth full calendar month after the date of the member's initial enrollment.

B. Exceptions to guaranteed period. The Administration shall not grant a guaranteed enrollment period or shall terminate a guaranteed enrollment period as provided in subsection (C), if the member:

1. Did not meet the conditions of eligibility when initially enrolled with the contractor;
2. Except as provided in 9 A.A.C. 22, Article 12, is an inmate of a public institution as defined in 42 CFR 435.1010;
3. Dies;
4. Moves out-of-state;
5. Voluntarily withdraws from the AHCCCS program;
6. Is adopted; or
7. Has whereabouts that are unknown.

C. Disenrollment effective date. The Administration shall terminate any guaranteed enrollment period to which the member is not entitled effective on:

1. The date the member is admitted to a public institution under subsection (B);
2. The member's date of death;
3. The last day of the month in which the Administration receives notification that a member moved out-of-state;
4. The date the Administration receives written notification of the member's voluntary withdrawal from the AHCCCS program;

5. The last day of the month in which the Administration receives notification that a member’s adoption proceedings are finalized; or

6. The last day of the month in which the Administration receives notification that a member’s whereabouts are unknown.

D. Retroactive adjustments. The Administration shall adjust the member's eligibility and enrollment retroactively under subsection (C).